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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION

CALIFORNIA HOSPITAL ASSOCIATION; DOES 1-5, Plaintiffs, vs. TOBY DOUGLAS, Director of the State Department of Health Services, State of California; KATHLEEN SEBELIUS, Secretary of the United States Department of Health and Human Services, Defendants.	CASE NO. **COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF**

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JURISDICTION AND VENUE

1. Plaintiffs, the California Hospital Association ("CHA") and Does 1-5, brings this complaint pursuant to 28 United States Code ("U.S.C.") § 1331, the Supremacy Clause, 42 U.S.C. § 1983 and the Administrative Procedure Act ("APA), as codified at 5 U.S.C. § 706, *et. seq. Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n. 14 (1983). This court further may compel Defendant Toby Douglas, Director of the California Department of Health Care Services (the "Director") and Kathleen Sebelius, Secretary of the United States Department of Health and Human Services ("Secretary"), to comply with the mandatory provisions of the federal Medicaid law pursuant to 28 U.S.C. § 1361.

2. Venue lies in this judicial district under 28 U.S.C. § 1391, in that the Director has offices within this judicial district and is thus deemed to reside within this judicial district and also in that plaintiffs or their members are located and reside within this judicial district and the consequences of Defendants' unauthorized and arbitrary activities are occurring within this judicial district.

INTRODUCTION

3. The State of California is set to unleash a reduction of unprecedented magnitude in the rates at which hospitals are compensated under the State's Medicaid program, Medi-Cal, for providing skilled nursing care to Medi-Cal beneficiaries. Once effective, this latest reduction will result in hospitals getting in *excess of twenty percent less* than what they currently are being paid for furnishing the impacted services. This "mega" rate reduction is remarkable for many reasons, but one in particular is that it represents the resurrection of multiple prior rate reductions and limitations that were previously promulgated by the State, but found to be in violation of the federal Medicaid Act. Apparently wholly undeterred by what this court, and the Court of Appeal for the Ninth Circuit says the Medicaid Act requires, the State has not only brought back those prior limitations, which

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significantly reduce payments, but is adding an additional 10 percent reduction on top of them. Add to that the fact that a California Court of Appeal has determined that the entire methodology for how the payment rates in question are determined in the first place is invalid under federal law and artificially reduces provider payments. In short, with the action being challenged here, the State has effectively rolled three unlawful cuts and limitations into one, and then cut the rates even further for good measure, all in the name of budgetary savings.

4. Somewhat miraculously, notwithstanding the sordid history behind the rate reduction at issue, the federal agency charged with administering the Medicaid program, the Centers for Medicare and Medicaid Services ("CMS"), has found that the reduction is consistent with Medicaid Act requirements and, in particular, poses no risk that Medi-Cal beneficiary access to skilled nursing services will be impacted. Aside from being wholly inconsistent with governing case law concerning what the Medicaid Act requires, CMS' decision simply defies reason and logic. It strains credulity to its breaking point to accept that the State could take rates that, from the outset, are skewed against providers, then reduce them by 10 percent, then not adjust the rates to reflect increased provider costs over a period of three years and then reduce them by another 10 percent, all without having any adverse impact on provider participation levels in Medi-Cal. Nevertheless, as discussed below, that is effectively what CMS determined.

5. By this action, an organization representing the interests of California hospitals seeks an injunction to invalidate and stop the implementation of this latest "mega" cut to the rates paid under Medi-Cal for hospital based skilled nursing services. On the most immediate level, this new payment reduction will improperly deprive Medi-Cal participating hospitals of reimbursement to which they otherwise are lawfully entitled. However, contrary to what the State and CMS have determined, and even more alarmingly, this massive payment reduction will almost immediately threaten the ability of many hospitals to continue to operate skilled

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nursing units. When these units are forced to close, it will, at worst, create significant gaps in access to such services for Medi-Cal beneficiaries, particularly those residing in already medically underserved, rural areas and, at best, cause significant delay in patients obtaining needed services. Moreover, when hospital-based skilled nursing care becomes unavailable in many areas, it will likely result in some patients who are in need of the level of nursing care provided in these types of facilities being forced to remain in more expensive, acute care settings or being transferred to freestanding nursing facilities, which are less qualified to provide the care they need.

6. As were its predecessors, this latest budget driven reduction for hospital based skilled nursing care is contrary to federal law and numerous rulings by this Court and the Ninth Circuit Court of Appeals concerning the obligations imposed by the Medicaid Act. Further, when operating in conjunction with California State laws that place restrictions on the ability of skilled nursing facilities to close outright or withdraw from Medi-Cal, the rate reductions are going to effectively seize the private property of hospitals without adequate compensation in violation of the respective Takings Clauses of the United States and California Constitutions.

7. Consistent with the foregoing, Plaintiffs seek declaratory and injunctive relief to prevent the State of California from implementing and/or enforcing this unlawful, enormous payment reduction and setting aside CMS' approval of it.

THE PARTIES

8. Defendant TOBY DOUGLAS is the Director of the Department of Health Care Services and as such, has the responsibility to administer the Medi-Cal program consistent with the federal Medicaid Act. The Director is sued in his official capacity. The Department is the single state agency charged with the administration of California's Medicaid program, known as Medi-Cal. *See* California Welf. & Inst. Code §§ 14000 *et seq.* The Director has an office in the

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County of Los Angeles.

9. Defendant KATHLEEN SEBELIUS, the Secretary of the United States Department of Health and Human Services ("Secretary"), is the federal officer responsible for administering the Medicaid program at the federal level. The Secretary, through her designated agent, the Centers for Medicare and Medicaid Services ("CMS"), is responsible for reviewing and approving policy changes that states make to their Medicaid program. The Secretary has approved the policy changes that California has made to Medi-Cal, which Plaintiff is challenging herein.

10. Plaintiff CHA is a trade association representing the interests of hospitals in the State of California. CHA is incorporated in the State of California with its principal office in Sacramento, California. CHA's member hospitals provide both inpatient and outpatient hospital services. Many of CHA's members operate skilled nursing facilities that are distinct part units within the hospital, commonly referred as "DP/NFs." Many CHA members that operate DP/NFs, including privately owned hospitals, participate in Medi-Cal and provide skilled nursing care to needy Medi-Cal beneficiaries. CHA represents nearly 450 hospitals and health systems throughout California, including general acute care hospitals both small and large, children's hospitals, rural hospitals, psychiatric hospitals, academic medical centers, county and other public hospitals, investor-owned hospitals, privately owned non-profit hospitals and multi-hospital health systems. These hospitals furnish vital health care services to millions of the State's citizens. CHA brings this action on its own behalf and in its representative capacity on behalf of its members, many of which are providers of DP/NF services under California's Medi-Cal program and will be directly and adversely affected by the challenged rate limitations, and on behalf of its members' patients.

11. Plaintiffs DOES 1-5 are individuals residing in the State of California. Plaintiffs Does 1-5 are beneficiaries of the Medi-Cal program who require skilled nursing services. These individual Medi-Cal beneficiary plaintiffs have been

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receiving DP/NF services from hospitals that are CHA members and have been and/or will be adversely affected by the Medi-Cal payment rate reductions at issue in this action, to the extent those reductions will cause the DP/NFs at which these patients are currently residing to close or otherwise limit services.

FEDERAL MEDICAID LAW

12. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*, the Medicaid Act, authorizes federal financial support to states for medical assistance to low-income persons who are aged, blind, disabled, or members of families with dependent children. The program is jointly financed by the federal and state governments and administered by the states. The states, in accordance with federal law, decide eligible beneficiary groups, types and ranges of services, payment level for services, and administrative and operative procedures. Payment for services is made directly by states to the individuals or entities that furnish the services. 42 Code of Federal Regulations ("C.F.R.") § 430.0.

13. In order to receive matching federal financial participation, states must agree to comply with the applicable federal Medicaid law and regulations, 42 U.S.C. §§ 1396 *et seq*. Once a state has decided to participate in the Medicaid program, compliance with the federal Medicaid law and regulations is mandatory.

14. At the state level, the Medicaid program is administered by a single state agency, which is charged with the responsibility of establishing and complying with a state Medicaid plan (the "State Plan") that, in turn, must comply with the provisions of applicable federal Medicaid law. 42 U.S.C. § 1396a(a)(5) and 42 C.F.R. §§ 430.10 and 431.10. The State Plan must be submitted to the Secretary of the United States Department of Health and Human Services (the "Secretary") for approval and must describe the policies and methods to be used to set payment rates for each type of service included in the state Medicaid plan. 42 C.F.R. §§ 430.10 and 447.201(b). Under federal Medicaid law, as interpreted by the Court of Appeals

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for the Ninth Circuit, Changes to the State Plan may not be implemented by the state prior to being approved by the Secretary.

15. The Secretary's review and approval of any Medicaid state plan amendment as satisfying the requirements of the Medicaid Act is reviewable under the APA, 5 U.S.C. § 706, *et seq.* Under the APA, agency action may be set aside where it is found to be arbitrary and capricious, an abuse of discretion or otherwise unsupported by substantial evidence. Among other things, an agency acts arbitrarily and capriciously when it fails to follow governing law with respect to a particular decision or action. Further, to comply with the APA, the Secretary must develop a record demonstrating adequate consideration of the relevant factors and a rational basis for her decision on the relevant SPA.

16. Each state's Medicaid plan must provide that "medical assistance" will be furnished *with reasonable promptness* to all eligible individuals. 42 U.S.C § 1396a(a)(8) ("Section (a)(8)").

17. Each state's Medicaid plan must "provide such safeguards as may be necessary to assure that... care and services will be provided [] in a manner consistent with... *the best interests of the recipients.*" 42 U.S.C. § 1396a(a)(19) ("Section (a)(19)").

18. Each state's Medicaid plan must "provide such methods and procedures . . . relating to the utilization of, and the payment for, care and services available under the plan which may be necessary . . . *to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general public in the geographic area* . . . ." 42 U.S.C. § 1396a(a)(30)(A) (hereinafter "Section 30(A)") (emphasis added); 42 C.F.R. § 447.204. Section 30(A) has been interpreted by the Ninth Circuit Court of Appeals to require state Medicaid agencies to consider provider costs, based on "reasonable cost" studies, when setting Medi-Cal payment

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rates and to preclude states from basing Medicaid rate setting decisions solely on budgetary factors. Further, as interpreted by the Ninth Circuit Court of Appeals, Section 30(A) requires that the rates paid by a Medicaid program for services must bear a reasonable relationship to the costs that an efficiently and economically operated provider incurs in rendering such services.

CALIFORNIA'S MEDI-CAL PROGRAM

19. The State of California has elected to participate in the Medicaid program. California has named its program "Medi-Cal." *See* Cal. Welf. & Inst. Code §§ 14000 *et seq.*; 22 Cal. Code of Regs. ("C.C.R.") §§ 50000 *et seq.*

20. Medi-Cal healthcare payments are disbursed in two ways. The first is a "fee for service" process whereby the Department of Health Care Services (the "Department" or "DHCS") determines whether the healthcare services were covered and furnished to an eligible beneficiary, and, if so, pays the service providers directly. Alternatively, the Department administers Medi-Cal through various managed care models operated by public and private entities under contract. This action concerns only payments made under the fee-for-service component of the Medi-Cal program.

21. The Medi-Cal program covers skilled nursing care provided to eligible Medi-Cal beneficiaries, provided certain requirements are met. 22 C.C.R. § 51335. For Medi-Cal purposes, a skilled nursing level of care is defined as "the level of care needed by Medi-Cal beneficiaries who do not require the full range of health care services provided in a hospital as acute care or hospital extended care, but who require the continuous availability of skilled nursing care provided by licensed registered or vocational nurses." 22 C.C.R. § 51124(b). Medi-Cal covered skilled nursing care can be furnished in any institution that is licensed by the State as skilled nursing facility, including a distinct part unit of a hospital. 22 C.C.R. § 51121. As mentioned above, skilled nursing facilities that are hospital units are

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commonly referred to in the Medi-Cal context as "DP/NFs." In contrast, nursing facilities that are not hospital based are known as "freestanding SNFs."

22. Due to the type of patients that generally required skilled nursing care, in addition to other factors, a significant portion of funding provided to many skilled nursing facilities, both DP/NF and freestanding SNFs, comes from the Medi-Cal program. As a result, many of these facilities are highly dependent on the Medi-Cal program for their funding and financial survival.

23. Notably, although both DP/NFs and freestanding SNFs can furnish Medi-Cal covered skilled nursing care, on a general level, there are significant differences in the types of patients treated, and care provided, between these two classes of facilities, such that the two types of facilities are not interchangeable . In particular, patients treated in DP/NFs often present more complex medical issues and require more resources, including highly skilled nursing care and ancillary services, than do patients treated freestanding SNFs. Accordingly, in many cases, freestanding SNFs cannot, or are not available to, provide care to more complex patients that is equivalent to the care that would be rendered in a DP/NF.

MEDI-CAL PAYMENTS TO HOSPITALS FOR SKILLED NURSING CARE

24. Payments from the Medi-Cal fee for service program to hospitals are governed by various statutes, regulations, the State Plan, and in some instances, informal handbooks, manuals or bulletins.

25. Payments for services provided by DP/NFs are governed by 22 C.C.R. § 51511 and Attachment 4.19-D to the State Plan. Reimbursement is the lower of (1) a per diem rate based on a particular hospital's projected costs of providing DP/NF services, based on prior year data or (2) a statewide per diem "median" rate computed by the Department. Under the State Plan, the Department is required to re-evaluate Medi-Cal payment rates for DP/NF services on a yearly basis. The

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Department generally is required to make updates to payment rates each year to account for certain economic conditions in the industry, which reflect an assumption that provider costs will generally increase every year due to, at minimum, inflation.

THE STATE'S REPEATED UNLAWFUL REDUCTION OF DP/NF PAYMENT RATES

26. Since the late 1990s, the State of California has repeatedly engaged in efforts to freeze, reduce or otherwise limit the rates of reimbursement paid to DP/NFs under Medi-Cal. Most of these measures have been subject to legal challenge and found to be unlawful, or likely unlawful, under the Medicaid Act. Nevertheless, the State is effectively incorporating all these prior limits and reductions into rate cut at issue in this action.

27. Commencing with the 1995-1996 Medi-Cal rate year, the Department adopted a regulation that altered the methodology for computing per diem reimbursement rates for DP/NFs. Specifically, the regulation establishes that, in calculating the DP/NF payment median for any given year, which is a ceiling on the payment rates, the Department excludes consideration of cost data from DP/NF providers that, on average, have a Medi-Cal patient utilization of less than 20 percent, that is, the percentage of Medi-Cal patient days in the DP/NF is less than 20 percent of the DP/NF's total patient days. This "exclusion methodology" artificially decreases per diem payment rates and that, absent application of this methodology, payment rates for all Medi-Cal participating DP/NFs would be higher.

28. The "exclusion methodology" has been subject to multiple court challenges. Most recently, Plaintiff CHA challenged, through a writ of mandate proceeding in California State court, the Department's application of the exclusion methodology in the calculation of DP/NF reimbursement rates for all Medi-Cal rate years between 2000-2001 and 2005-2006. CHA alleged in that case that the exclusion methodology was invalid under Section 30(A) because, both in originally

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adopting the exclusion methodology and applying in the rate years at issue therein, the Department never appropriately considered whether the payment rates resulting from the exclusion methodology were reasonably related to costs and consistent with efficiency and economy of care. CHA also alleged that the fundamental assumption underlying the exclusion methodology, *e.g.*, that facilities which do not treat a high number of Medi-Cal beneficiaries have "inflated" costs, was untested, unsupported by relevant data and substantively incorrect.

29. In 2010, a California Court of Appeal agreed with CHA in a published opinion in which it declared that the exclusion methodology was invalid as not consistent with Section 30(A). *See California Hospital Ass'n v. Maxwell-Jolly*, 188 Cal. App.4th 559, 115 Cal. Rptr.3d 572 (Cal. Ct. App. 2010). The Court of Appeal remanded the case back to the State superior court for further proceedings consistent with its opinion, but did not order the Department to stop applying the exclusion methodology (and those proceedings are currently pending). Consequently, the exclusion methodology remains a component of the Department's rate setting process for DP/NFs.

30. In early 2008, through Assembly Bill X4 5 ("2008 AB 5"), the California Legislature mandated a flat ten percent reduction in the rates of reimbursement paid to, among other classes of facilities, DP/NFs. This reduction, which was effectuated through the enactment of Welfare & Institutions Code 14105.19, went into effect for services rendered on or after July 1, 2008. CHA joined with a coalition of other provider associations to challenged the 2008 AB 5 reimbursement reduction as being in conflict with, among other Medicaid Act provisions, Section 30(A). The litigation concerning the 2008 AB 5 payment reductions ultimately culminated in a published Ninth Circuit decision affirming a district court order enjoining the Department from applying the rate reduction to most classes of impacted providers. In *Indep. Living Ctr. Of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009) [hereinafter "*ILC II*"], the Ninth Circuit

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affirmed the district court 's determination that the plaintiffs in the case were likely to prevail on their claim that 2008 AB 5 was not enacted in accordance with, and therefore is preempted by, Section 30(A) because the State Legislature enacted the rate cut for purely budgetary reasons, without consideration of reliable cost studies or analysis of the potential impact of the rate reductions on beneficiary access to care.

31. The 2008 AB 5 rate reductions were never enjoined with respect to any classes of hospital services, including services rendered in DP/NFs, because the district court determined that hospitals did not demonstrate irreparable harm resulting from the rate reduction in the form of reduced Medi-Cal beneficiary access to hospital services. Neither CHA or any other plaintiff representing the interests of hospitals appealed this conclusion by the district court.

32. On September 18, 2008, after a protracted budget stalemate, then Governor Schwarzenegger signed Assembly Bill 1183 ("AB 1183"), the budget trailer bill for fiscal year 2008-09. AB 1183 amended Welfare and Institutions Code § 14105.19, making most aspects of the 2008 AB 5 rate reductions effective only through February 29, 2009, including rate cuts for DP/NF services. However, through the enactment of Welfare and Institutions Code § 14015.191, AB 1183 mandated a five percent rate reduction for Medi-Cal fee-for-services benefits paid to, among other facilities, DP/NFs, effective for services rendered on or after March 1, 2009.

33. On January 29, 2009, a coalition of Medi-Cal providers and provider organizations, including CHA, filed a complaint in district court against the Director challenging the AB 1183 Rate Reductions on the grounds that AB 1183 was not enacted in accordance with the requirements of the Medicaid Act, including those set forth in Section 30(A). On February 11, 2009, CHA and other individual hospital plaintiffs filed a motion in the district court seeking a preliminary injunction to prohibit implementation of the AB 1183 rate cuts for hospital services.

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34. On March 9, 2009 the district court issued an order denying the hospital plaintiffs' injunction motion concerning the AB 1183 rate reductions. Although the district court concluded that the hospital plaintiffs demonstrated a substantial likelihood of prevailing on their claims that the AB 1183 rate reductions conflicted with, and therefore are preempted by, Section 30(A), the court concluded there was not a demonstration that hospitals would be irreparably harmed by the reduced payment rates by virtue of the fact beneficiary access to hospital services would be reduced as a result of the rate reductions. In reaching this decision, the district court rejected an argument by CHA and the other hospital plaintiffs that hospitals necessarily were irreparably harmed by the AB 1183 rate reductions because they are precluded by the Eleventh Amendment from obtaining retroactive compensation from the State in federal court for any under-reimbursement.

35. CHA and the other hospital plaintiffs appealed the district court's order on March 11, 2009. The next day, they filed an emergency motion with the Ninth Circuit seeking a temporary stay of the AB 1183 rate reductions for hospitals on the grounds that the district court committed legal error by not finding that hospitals were faced with irreparable harm by virtue of reduced Medi-Cal payment rates.

36. The emergency motion was granted in a published decision from the Ninth Circuit. *See California Pharmacists Ass'n v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009) ("*Cal. Pharm. I*"). In *Cal. Pharm. I*, the Ninth Circuit concluded that the plaintiffs showed that AB 1183 likely was preempted by Section 30(A) because the statute, and the Medi-Cal rate cuts called for thereby, were enacted without consideration of efficiency, economy, quality of care and the impact on beneficiary access to services. *Id.* at 851. *Cal. Pharm. I* also establishes that, for preliminary injunction purposes, unlawfully reduced Medi-Cal reimbursement constitutes an injury to the providers subject to the decreased rates and that such an injury is irreparable when, due to sovereign immunity, the reimbursement differential cannot be recovered in federal court. *Id.* at 851 - 853.

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37. Based on the aforementioned findings, the *Cal. Pharm. I* court stayed the AB 1183 rate reductions impacting hospitals, including DP/NFs. Subsequently, in a memorandum opinion, and relying on the same rationale set forth in *Cal. Pharm. I*, the Ninth Circuit reversed the district court's decision denying the hospital plaintiffs an injunction of the AB 1183 rate reductions and remanded the matter back to the district court for issuance of such an injunction order. Accordingly, on April 16, 2010, the district court issued an order enjoining the Department from applying the 5 percent reduction called for by AB 1183 to hospital services, including those rendered by DP/NFs. As of the filing of this Complaint, that injunction remains in effect.

38. On July 28, 2009, after four extra legislative sessions, then Governor Schwarzenegger signed into law Assembly Bill X4 5 ("2009 AB 5"), the budget trailer bill for California fiscal year 2009 – 2010. Although, unlike the last two California budget trailer bills, 2009 AB 5 did not make any flat percentage reductions to Medi-Cal payment rates, the bill enacted or amended multiple statutes in order to limit Medi-Cal reimbursement for several classes of hospital services.

39. 2009 AB 5 amended Welfare and Institutions Code § 14105.191 to effectively "freeze" the Medi-Cal payment rates for, among other things, DP/NFs at 2008 – 2009 levels. Specifically, the statute, as amended by 2005 AB 5, now provides that, for the designated services, "reimbursement rates . . . for services rendered during the 2009 – 10 rate year and each rate year thereafter, shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008-09 rate year." In effect, the amended version of the statute indefinitely suspends the annual payment updates for these classes of services that are otherwise required by the State Plan.

40. CHA initiated a challenge to the 2009 AB 5 rate limitations in November 2009. In *California Hospital Association v. Maxwell-Jolly*, Case No. 09-08642, by order dated February 24, 2010, the United States District Court for the

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Central District of California preliminarily enjoined the Director from applying or otherwise enforcing the 2009 AB 5 reimbursement limitations with respect to, among other things, DP/NF services based on findings that 2009 AB 5 was enacted by the Legislature without adherence to the requirements of Section 30(A) and that hospitals were being irreparably harmed by the decreased Medi-Cal reimbursement resulting from the limitation, which could not be recovered in an action for damages due to the State's Eleventh Amendment immunity. That injunction order remains in effect.

ASSEMBLY BILL AB 97 OF 2011

41. On March 25, 2011, Governor Brown signed into law Assembly Bill 97 of 2011 ("AB 97"), the health budget trailer bill for California fiscal year 2011 – 2012. As it has done so often in recent years, with AB 97, the State of California once again enacted significant payment reductions for many classes of services provided under the Medi-Cal program.

42. Most significantly for the present action, AB 97 enacts Welfare and Institutions Code § 14105.192, which authorizes the Director to reduce the Medi-Cal payment rates for various categories of services, effective June 1, 2011. Most of the rate reductions called for in the statute are simple, flat 10 percent reductions. However, pursuant to Section 14105.192(j), reimbursement for certain services "shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008-09 rate year, as described in subdivision (f) of Section 14105.91, reduced by 10 percent." Among the services impacted by this provision, are DP/NF services. (Curiously, there is no Section 14105.91 in the Welfare and Institutions Code. It appears that the Legislature intended to refer either to Section 14105.19 or section 14105.191 in AB 97).

43. Notwithstanding the difficulty in tracking the reference to Section 14105.91 in Section 14105.192(j), Plaintiffs are informed and believe and thereon

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allege, that the Department will apply Section 14105.192(j) to limit DP/NF payment rates to the rates in effect as of August 1, 2008, less 10 percent of those already reduced rates. Plaintiffs are informed and believe and thereon allege that such an application of the statute will result in an aggregate effective payment reduction in DP/NF rates of between 23 and 28 percent.

44. Pursuant to Section 14105.192(m), the reductions in Section 14105.192 cannot be implemented until the Director determines they are consistent with federal law. Pursuant to Section 14105.192(n), the Director is required to seek any federal approvals necessary to implement section 14105.192. Pursuant to section 14105.192(o), the Director may not implement any of the reductions in section 14105.192 "until federal approval is obtained." However, the statute provides that once federal approval is obtained, the reductions may be implemented retroactively as of June 1, 2011.

45. Plaintiffs are informed and believe and thereon allege that, prior to giving DHCS the authority to reduce DP/NF payment rates pursuant to Section 14105.192, the California Legislature did not conduct or commission any reliable cost studies to determine whether the altered payment rates would be consistent with efficiency, economy, quality of care, sufficient to ensure continued adequate access to care for Medi-Cal beneficiaries or reasonably related to the costs hospitals incur in furnishing the DP/NF services. Rather, all the rate reductions called for by AB 97, including the reductions in DP/NF rates, were enacted by the Legislature for solely budgetary purposes.

46. The Medi-Cal payment rate reduction called for by AB 97, as codified at Section 14015.192, for services rendered by DP/NFs shall be referred to hereinafter as the "2011 DP/NF Rate Reduction."

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FEDERAL APPROVAL OF THE 2011 DP/NF RATE REDUCTION

47. Consistent with the terms of Section 14105.192, DHCS submitted a proposed State Plan Amendment or "SPA" to CMS on June 30, 2011, which sought federal approval of the 2011 DP/NF Rate Reduction and incorporation of that reduction into California's Medi-Cal State Plan.

48. According to information that Plaintiff CHA received from the State, at the time the proposed SPA concerning Section 14105.192, designated by DHCS as 11-010, was submitted to CMS, it was not accompanied by any materials purporting to evaluate whether the proposed rate reduction was consistent with the requirements of the Medicaid Act other than "interim drafts of portions of an access analysis."

49. In July 2011, through a request submitted under California's Public Records Act ("PRA"), as codified at California Government Code §§ 6250, *et seq.*, Plaintiff CHA sought all materials submitted by DHCS to CMS in connection with SPA 11-010, as well as other concurrently submitted SPAs. CHA made this request so that it could review and evaluate the materials the Department submitted to CMS in support of, among other things, the 2011 DP/NF Rate Reduction and, if necessary, provide additional relevant information to CMS in response to the State's submission that would be relevant to CMS' evaluation of the SPAs in question, including SPA 11-010.

50. On July 26, 2011, DHCS responded to CHA's PRA request and indicated that there were no responsive materials other than the SPA documents themselves. The letter further advised that DHCS would not provide CHA with access to the "interim drafts of portions of an access analysis" that were submitted to CMS in conjunction with SPA 11-010 on the ground that those materials were not subject to disclosure under the PRA due to a "Deliberative Process Privilege."

51. At the same time CHA was seeking materials from DHCS concerning the SPA on the 2011 DP/NF Rate Reductions, it was also communicating with CMS

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concerning the State's efforts to get two other SPAs concerning a previously enacted DP/NF rate limitations approved. Those limitations, which are discussed above, called for first, a 5 percent reduction in DP/NF rates effective March 1, 2009, and then a suspension in any annual updates to DP/NF rates, effective August 1, 2009. In July 2011, CHA provided extensive information to CMS concerning why the SPAs for the 2008 and 2009 DP/NF payment limitations should not be approved. CHA's submission, which included data analysis from an reimbursement expert, explained that, among other things: (1) low Medi-Cal reimbursement rates were already starting to lead to the closure of DP/NF facilities; (2) Medi-Cal beneficiaries already were starting to experience difficulties in accessing skilled nursing care, including significant delays in transferring from the hospital setting to freestanding SNFs; and (3) that, even before application of the reductions at issue in the SPAs, DP/NFs were already being reimbursed by Medi-Cal at rates significantly below their costs. In short, CHA presented extensive data to CMS showing that, even without application of the 2011 DP/NF Rate Reduction, the State's payment policies for DP/NF were creating access problems for beneficiaries with respect to skilled nursing services.

52. By later dated August 11, 2011, CHA notified CMS about how DHCS declined to turn over materials related to SPA 11-010 and others in response to CHA's public records request. In the letter, CHA questioned how it would be possible for CMS to conduct a full and adequate review of SPA 11-010 if DHCS had not yet submitted complete and final information to CMS about the probable impact of the relevant rate cut on, among other things, beneficiary access to services. CHA also reiterated that it was critical to the hospitals that the association represents that it be afforded an opportunity to review and comment on the materials DHCS submitted in support of the proposed rate reductions, including the 2011 DP/NF Rate Reduction. Accordingly, in the letter, CHA requested, under the federal Freedom of Information Act ("FOIA"), that CMS disclose all materials

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exchanged between DHCS and CMS concerning, among other things, SPA 11-010. That same day, CHA received a form letter from CMS in response to the FOIA request, which indicated in vague terms that the request was being processed.

53. In September 2011, in conjunction with the various SPAs pending concerning limitations on DP/NF payment rates, particularly the 2011 DP/NF Rate Reduction, CHA commissioned a "Special Report" concerning Medi-Cal beneficiary access to skilled nursing care. This report was prepared by an independent third party consultant and, in general, concludes that Medi-Cal beneficiary access to hospital based skilled nursing care was already suffering under then-existing Medi-Cal rates and would only decrease further if additional payment rate reductions were implemented. The Special Report also explains in detail the unique role that DP/NFs play in the patient care continuum, including a discussion of why DP/NF care is not interchangeable with care provided in freestanding SNFs. This Special Report was provided initially to CMS on September 14, 2011.

54. On September 27, 2011, while CHA was still awaiting meaningful responses from either DHCS or CMS to the PRA and FOIA requests, respectively, it has submitted concerning SPA 11-010, CMS issued a letter to DHCS, which responded to the SPA by asking DHCS to submit additional information concerning the proposed rate reduction. This Request for Additional Information ("RAI") was fairly extensive and included a list of sixteen inquiries that CMS felt DHCS needed to address in order to allow CMS to appropriately assess whether the rate reduction called for in the SPA 11-010 would be consistent with the Medicaid Act.

55. During the week of October 13, 2011, CHA received from CMS materials related to SPA 11-010 that had been previously submitted by DHCS. Those materials did not include any information that DHCS submitted directly to CMS in response to the September 27, 2011 RAI. In conjunction with receipt of this information, CHA sent CMS a letter urging the agency to delay consideration of SPA 11-010 in order to allow CHA to review and comment on the documentation

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that DHCS had submitted to CMS in support of the rate reductions. As part of that request, CHA also indicated that it wanted an opportunity to review whatever additional information DHCS submitted to CMS in response to the RAI. CHA noted that it was critical it be afforded this opportunity because the 2011 DP/NF Rate Reduction was likely to have an unprecedented adverse impact on California hospitals and the Medi-Cal program as a whole.

56. On October 27, 2011, CHA submitted a letter to CMS addressing the materials DHCS had submitted to CMS in support of SPA 11-010 prior to the September 27, 2011 RAI. As of the time of the preparation of the October 27, 2011 letter, CHA had not received from either CMS or DHCS any materials that DHCS has prepared specifically in response to the RAI. CHA's October 27, 2011 letter to CMS explained in detail why any purported studies DHCS had conducted with respect to whether the 2011 DP/NF Rate Reduction would be consistent with Medicaid Act requirements were "woefully" inadequate. CHA pointed out that DHCS' assessment of the impact that the rate reduction would have on beneficiary access to skilled nursing services was based on skewed and incomplete data and on the fundamentally flawed assumption that the services rendered by DP/NFs and freestanding SNFs are essentially fungible. In addition, among other things, CHA also pointed out that DHCS' analyses failed to address the significant geographical differences in terms of access to skilled nursing care as between rural and non-rural areas. Finally, CHA noted that DHCS analyses were devoted exclusively to assessing the impact of the 2011 DP/NF Rate Reduction on access and did not at all consider the impact of the rate reduction on qualify of services and questions of efficiency, which are also relevant factors under the Medicaid Act. The entire discussion in CHA's October 27, 2011 proved to be for naught, however, since CMS's decision on SPA 10-010 had already been made.

57. By letter dated October 27, 2011, CMS provided notice that it was approving SPA 11-010, including the 2011 DP/NF Rate Reduction, The SPA

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approval letter indicated that CMS' decision was based on the fact that the "State was able to provide metrics which adequately demonstrated beneficiary access." Those "metrics" included information about "total numbers of providers by type and geographic location" participating in Medi-Cal, "total number of Medi-Cal beneficiaries by eligibility type," and "utilization of services over time." CMS also indicated that it accepted DHCS' plan to monitor access to services going forward. There is no reference in the October 27, 2011 letter from CMS approving SPA 11-010 to any considerations of the impact of the 2011 DP/NF Rate Reduction on quality of care or efficiency.

58. Plaintiffs are informed and believe and thereon allege that, given that CMS has approved the SPA, DHCS imminently intends to start applying the new limitation to DP/NF payments, including through the retrospective recovery of purported "overpayments" for services rendered on or after June 1, 2011 that were paid at the unreduced rate in effect during that period.

THE ILLEGALITY OF 2011 DP/NF RATE REDUCTION

59. Violation of the United States and California Constitutions, Takings Clause: California law places restrictions on the ability of participating skilled nursing facilities, including DP/NFs, to both withdraw from Medi-Cal and cease operations. *See, e.g.* Cal. Health & Safety Code § 1336.2 and Cal. Welf. & Inst. Code § 14022.4. Such facilities are not permitted to immediately stop treating patients, but rather must take extensive steps to ensure that their patients are transferred to other patient facilities. However, in some instances, this class of facilities may be required, by statute, to continue treating particular patients who refuse transfer to other facilities. Along these longs, skilled nursing facilities may only effectively withdraw from the Medi-Cal program when all Medi-Cal patients have left the care of the facility. California law therefore compels skilled nursing facilities, including DP/NFs, to furnish services to Medi-Cal beneficiaries for at

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least a certain period of time, which constitutes an appropriation of these facilities and a taking of their private property by the State of California. Due to the outrageously low rates at which the Medi-Cal program will compensate DP/NFs after the 2011 DP/NF Rate Reduction goes into effect, Plaintiff CHA's members that operate DP/NFs will not be justly compensated by the State for their property in violation of the Fifth and Fourteenth Amendments of the United States Constitution and Section 19, Article I of the California Constitution.

60. Violation of Federal Statute: The 2011 DP/NF Rate Reduction is invalid and may not lawfully be implemented because they violate federal Medicaid law, and are therefore preempted by the Supremacy Clause, because:

(a) The 2011 DP/NF Rate Reduction violates Section (a)(8) because it is going to effectively prevent many Medi-Cal beneficiaries from obtaining needed skilled nursing care with reasonable promptness. In many areas of the State Medi-Cal beneficiaries already have to be placed on waiting lists in order to access skilled nursing care. Due to the unprecedented magnitude of the 2011 DP/NF Rate Reduction, Plaintiffs are informed and believe and thereon alleged that many existing DP/NF providers are going to be forced out of business altogether or to severely restrict their services, or reduce the availability of services to Medi-Cal patients. As a result, Medi-Cal beneficiaries will not obtain skilled nursing services with reasonable promptness. In many areas of the State, there simply will be no available capacity at all in DP/NFs or freestanding SNFs. In other areas, there will be no available capacity among Medi-Cal providers of skilled nursing services to accept and care for Medi-Cal patients requiring skilled nursing care who have higher acuity and more complex conditions.

(b) The 2011 DP/NF Rate Reduction violates Section (a)(19) in that it will effectively dictate that skilled nursing care is being covered and reimbursed under Medi-Cal in a manner that is not in the best interests of patients for several reasons.

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(i) First, DP/NFs often furnish a higher level of care than freestanding SNFS, and often are the only source of higher level skilled nursing care in their communities. DP/NFs will be forced to close and/or restrict Medi-Cal services in response to the 2011 DP/NF Rate Reduction, thereby forcing patients to be placed in freestanding SNFs that may not provide the higher level of care that the more complex skilled nursing patients require. It is not in the best interests of higher acuity skilled nursing Medi-Cal patients to be placed in a facility that cannot provide the level of care that they potentially require.

(ii) Second, the closure of, or reduction in services by, DP/NFs will required patients to be placed in facilities that are very distant from the patients and their families' residences. It is not in the best interests of skilled nursing patients to have to travel long distances to get to a facility that can treat them and that will limit the ability of their loved ones to visit and support them.

(c) The 2011 DP/NF Rate Reduction violates Section 30(A) because:

(i) The Legislature gave DHCS the authority to reduce DP/NF payment rates, and DHCS exercised that authority, for purely budgetary reasons in order to achieve monetary savings for the State;

(ii) Neither the Legislature nor DHCS appropriately considered the factors of efficiency, economy, quality of care and access to services prior to authorizing and/or adopting the 2011 DP/NF Rate Reduction and seeking approval of such from CMS. Despite findings in multiple "studies" performed by DHCS that the rates paid under Medi-Cal to DP/NFs are adequate to ensure continued access to skilled nursing services for Medi-Cal beneficiaries, the Legislature and DHCS have not complied with the procedural requirements of Section 30(A). In particular, the Legislature gave DHCS the authority to implement the 2011 DP/NF Rate Reduction before a study was completed concerning the impact of that specific cut on the availability of skilled nursing services. Plaintiffs

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are informed and believe and thereon alleged that the fact there would be a new reduction in reimbursement for DP/NFs was a foregone conclusion before any purported study regarding that particular payment reduction was completed;

(iii) To the extent DHCS sought to amend the State Plan to implement the 2011 DP/NF Rate Reduction after purported studies of that particular reduction were completed, those studies cannot be considered adequate for the purposes of the requirements of Section 30(A). First, Plaintiffs are informed and believe and thereon alleged that the Department did not conduct any study of the relationship between provider costs and Medi-Cal payment rates after imposition of the 2011 DP/NF Rate Reduction. Rather, the only studies the State appears to have performed concerned beneficiary access to skilled nursing services. Second, with respect to the Department's conclusions about the impact of the proposed rate reduction on Medi-Cal beneficiary access to skilled nursing services, the Department's studies rely on factually unsupportable assumptions and comparisons and also contain numerous substantive and methodological flaws. Third, the Department's conclusions about continued beneficiary access to skilled nursing services are largely based on historical data concerning provider participation in Medi-Cal under previous payment rates. It is unreasonable to conclude that, because provider participation remained at a certain level under higher payment rates, participation will continue at that level once payment rates are significantly reduced. Finally, the Department's studies do not address all of the requirements of Section 30(A) in that they focus on beneficiary access to services only and do not assess the impact of the rate reduction on quality of care and efficiency;

(iv) The rates resulting from the 2011 DP/NF Rate Reduction are not reasonably related to provider costs and therefore are not consistent with quality of care or sufficient to ensure equal access to services. The State's own studies show that, after application of a much smaller, 5% rate reduction, California hospitals would, on average, be reimbursed at less than 80% of the costs they incur

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in providing DP/NF services to Medi-Cal beneficiaries. Accordingly, using the Department's own data, a reduction in rates by more than 20% is going significantly widen the gap between payment rates and costs. Indeed, CHA is informed and believes and on that basis alleges, that Medi-Cal DP/NF payments, as impacted by the 2011 DP/NF Rate Reduction, will on average reimburse about 60 to 65% of DP/NF costs. This discrepancy between Medi-Cal payment rates for DP/NF services and hospital costs is not "reasonable" for the purposes of the requirements of Section 30(A);

(v) The rates resulting from the 2011 DP/NF Rate Reduction are so far below the costs incurred by hospitals in providing DP/NF services to Medi-Cal beneficiaries that the rates are not consistent with quality of care. The reduced rates are lower than the costs efficiently incurred by DP/NFs in providing care to Medi-Cal beneficiaries and therefore are not consistent with quality of care. The reduced rates will result in Medi-Cal patients not having access to the level of care available in a DP/NF, but not available in freestanding SNFs in various areas of the State, and this is not consistent with quality of care. The reduced rates in certain areas of the State will result in patients having to travel to distant locations, away from their homes and families, to obtain skilled nursing services as DP/NFs in their area will close or limit services, which is not consistent with quality of care;

(vi) The rates resulting from the 2011 DP/NF Rate Reduction are sufficiently below the costs that hospitals incur in providing skilled nursing services to Medi-Cal beneficiaries that the rates are not sufficient to ensure that Medi-Cal beneficiaries have access to services to the same extent as the general population. As DP/NFs close or reduce the availability of services to Medi-Cal patients, there will no longer be adequate access for Medi-Cal patients to an appropriate level of skilled nursing care.

61. Violation of State Law: The 2011 DP/NF Rate Reduction is invalid and may not lawfully be implemented because it is in violation of State law in that

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the Director acted arbitrarily and capriciously in determining that the Medi-Cal payment rates resulting from the 2011 DP/NF Rate Reduction would be consistent with the requirements of Section 30(A). Under Section 14105.192, the Director is only authorized to implement, among other rate reductions, the 2011 DP/NF Rate Reduction based on a determination, "that that the payments that result from the application of this section will comply with applicable federal Medicaid requirements and that federal financial participation will be available." Welf. & Inst. Code § 14105.192(m). Under California law, administrative agencies are prohibited from acting in manner that is arbitrary, capricious, inconsistent with applicable law or lacking in evidentiary support. Further, agency decisions must be based on a consideration of all relevant factors and must demonstrate a rational connection between those factors and the choice made. Here, the Director's decision that the rates that will result from the 2011 DP/NF Rate Reduction will comply with the requirements of the federal Medicaid Act is arbitrary, capricious and lacking in evidentiary support because, among other reasons: (1) the Director effectively ignored evidence showing that DP/NFs services are not interchangeable with freestanding SNF services and evidence showing that DP/NFs have been closing at a steady rate recently in concluding that beneficiary access to skilled nursing care would not be impacted by the rate reduction; (2) the Director failed to adequately consider the factors of quality of care and efficiency in evaluating whether the 2011 DP/NF Rate Reduction meets Medicaid Act standards; and (3) the Director failed to account for governing law establishing that, under Section 30(A), provider payment rates must bear a reasonable relationship to the costs efficiently and economically operated providers incur in treating Medicaid beneficiaries.

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THE SECRETARY'S APPROVAL OF THE 2011 DP/NF RATE REDUCTION

62. Consistent with the foregoing, the Secretary's approval of the 2011 DP/NF Reduction, as set forth in SPAs 11-010, is invalid because it is arbitrary, capricious, an abuse of discretion and inconsistent with governing law for the following reasons:

(a) Because California is within the jurisdiction of the Ninth Circuit Court of Appeals, the Secretary is bound to apply the Ninth Circuit's interpretation of the Medicaid Act, including Section 30(A), when evaluating California SPAs for compliance with the Medicaid Act. The Ninth Circuit has held that Section 30(A) requires that Medicaid payment rates must be based on credible cost studies and must bear a reasonable relationship to provider costs in order to be consistent with quality of care and sufficient to ensure that beneficiaries have equal access to services. CHA is informed and believes, and on that basis alleges, that the Secretary has not applied the Ninth Circuit's interpretation of Section 30(A) in reviewing and approving the relevant SPA, but purported to consider only whether the rates may actually cause a reduction in beneficiary access to services. The Secretary has thus failed to follow and apply the applicable law.

(b) The question of whether Medi-Cal payment rates for DP/NFs are reasonably related to hospital costs is a relevant factor in the determination of whether the rates comply with Section 30(A). Plaintiff is informed and believes, and based thereon alleges, that the Secretary did not consider whether the Medi-Cal payment rates for DP/NFs after the implementation of the 2011 DP/NF Rate Reduction would bear a reasonable relationship to hospital costs in deciding to approve the relevant SPA.

(c) Plaintiff is informed and believes and thereon alleges that payment rates resulting from the 2011 DP/NF Rate Reduction would generally reimburse DP/NFs between roughly 60-65% of their costs. Accordingly, the

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Secretary could not have reasonably concluded that the rates resulting from the 2011 DP/NF Rate Reduction bear a reasonable relationship to costs. It was therefore arbitrary, capricious and an abuse of discretion for the Secretary to approve the relevant SPA.

(d) Plaintiffs are informed and believe and thereon allege that the Secretary did not consider other relevant factors in evaluating California's SPA related to the 2011 DP/NF Rate Reduction in that the Secretary did not adequately consider, among other things, the impact of the rate reduction on the quality of nursing care, whether the payment reductions would impact the promptness with which Medicaid beneficiaries are able to obtain DP/NF services and whether the reduction would impact the efficiency with which Medi-Cal services are delivered, perhaps through effectively eliminating certain DP/NF providers and thereby forcing Medi-Cal beneficiaries to either obtain care in freestanding skilled nursing facilities, which are not ideally suited to the level of care they need, or in acute care areas of hospitals, which provided more expensive care than DP/NFs.

(e) The record before the Secretary at the time she approved the SPA at issue demonstrates that the 2011 DP/NF Rate Reduction will adversely impact quality of care, and would not be sufficient to ensure that Medi-Cal beneficiaries would have equal access to services, because, among other things, the 2011 DP/NF Rate Reduction, which is effectively three reimbursement reductions rolled into one, will cause a significant deterioration in the financial health of many hospitals that will cause hospitals, among other things, to cut back, reduce and eliminate DP/NF services. The record before the Secretary demonstrates that hospitals that will be forced to take these types of actions include rural hospitals and critical access hospitals which are in many instances the only source of skilled nursing services for a large geographic region of the State. As a result, both Medi-Cal beneficiaries and other California residents will be faced with a situation in which needed health care services are not available, either at all, or within a

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reasonable time or distance. Further, with respect to quality of care, the evidence before the Secretary showed that, as DP/NFs close or reduce the availability of services to Medi-Cal patients, there will no longer be adequate access for Medi-Cal patients to an appropriate level of skilled nursing care.

(f) The Secretary's review and approval of SPA 11-010 also is arbitrary and capricious because it occurred in manner that was inconsistent with the Secretary's own public statements concerning the need for "transparency" in the SPA approval process. Interested parties, including CHA, were not afforded meaningful access to the information that was being exchanged between CMS and DHCS concerning the SPA. Rather, the only reason any of this information was provided at all was because CHA exercised its rights to public information under FOIA and California's PRA. Even then, DHCS refused to make the information available until after CMS made its decision to approve or disapprove the SPA, and CMS did not make information available to very shortly before it made its approval decision. Further, CMS refused to delay its approval decision to allow CHA to review and consider all of the information DHCS submitted in support of SPA 11-010. By reaching a decision on SPA 11-010 without affording interested parties an adequate opportunity to review the information DHCS submitted in response to CMS' RAI, the Secretary effectively rendered meaningless any public participation it had allowed in the process before that.

CHA'S STANDING AS AN ASSOCIATION

63. Many of CHA's members are Medi-Cal providers of DP/NF services. These Medi-Cal providers will suffer a concrete economic injury in the form of reduced payments for services by the unlawful implementation of the 2011 DP/NF Rate Reduction.

64. Moreover, Medi-Cal providers are in a unique position to advance the interests of Medi-Cal beneficiaries. The members of CHA, which provide services

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to Medi-Cal beneficiaries, have an extremely close relationship with their Medi-Cal beneficiary patients who seek that care. A Medi-Cal beneficiary cannot secure medical services without his/her health care providers, and without reimbursement by Medi-Cal for those services.

65. Medi-Cal providers are better positioned and informed as to the impact of a reimbursement rate cut on the services they intend to provide. Medi-Cal beneficiaries lack information about the effect of Medi-Cal reimbursement rates on providers in light of providers' costs and the further effect of a rate cut on the provision of services to Medi-Cal beneficiaries. Providers know the relationship of reimbursement to service and to their costs. As compared to beneficiaries, providers are in a better position to evaluate the State's decisional process and the data relied upon by the State in determining reimbursement rates. This informational hurdle is sufficient to confer standing on providers, who comprise substantial portions of Petitioner's membership, to assert the interests of their patients who are Medi-Cal beneficiaries.

66. Furthermore, Medi-Cal beneficiaries face economic hindrances to their ability to assert their own rights in this case. To qualify for Medi-Cal, an individual must demonstrate financial need for medical assistance from the State. In light of their finances and the cost of litigation, Medi-Cal beneficiaries may not be able to effectively protect their interests.

67. Consistent with the foregoing, CHA has a right and an enforceable interest to maintain this action against the Director under the Takings and Supremacy Clauses of the United States Constitution, the Takings Clause of the California Constitution, the Civil Rights Act, 42 U.S.C. § 1983 and the APA to enjoin the Director's continuing violation of the federal Medicaid law and to compel the Director to comply with the provisions of the applicable federal Medicaid law, as well as to challenge the Secretary's decision to approve the Director's implementation of the unlawful rate reduction.

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68. Moreover, Consistent with the foregoing, CHA, as an association representing the interests of California hospitals that participate in the Medi-Cal program and the Medi-Cal beneficiaries they treat, and as party seeking to compel the Director and Secretary to comply with their public duties as defined by federal law and state law, may maintain this action to: (1) enjoin Defendants' continuing violation of federal law and State law, as applicable; and (2) compel Defendant to comply with the provisions of the applicable law.

69. Under 28 U.S.C. § 2201, CHA is entitled to a declaration of its rights, its members' rights, and/or its members' patients' rights under federal Medicaid law.

FIRST CAUSE OF ACTION

(VIOLATION OF TAKINGS CLAUSE / SUPREMACY CLAUSE 42 U.S.C. § 1983)

(Against Defendant Director)

70. Plaintiff hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

71. California law places restrictions on the ability of participating skilled nursing facilities, including DP/NFs, to both withdraw from Medi-Cal and cease operations. *See, e.g.* Cal. Health & Safety Code § 1336.2 and Cal. Welf. & Inst. Code § 14022.4. Such facilities are not permitted to immediately stop treating patients, but rather must take extensive steps to ensure that their patients are transferred to other patient facilities. However, in some instances, this class of facilities may be required, by statute, to continue treating particular patients who refuse transfer to other facilities. Along these lines, skilled nursing facilities, including DP/NFs, may only effectively withdraw from the Medi-Cal program when all Medi-Cal patients have left the care of the facility. California law therefore compels skilled nursing facilities, including DP/NFs, to furnish services to Medi-Cal beneficiaries, which constitutes an appropriation of these facilities and taking of

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their property by the State of California. Due to the outrageously low rates at which the Medi-Cal program will compensate DP/NFs after the 2011 DP/NF Rate Reduction goes into effect, Plaintiff CHA's members that operate DP/NFs will not be justly compensated by the State for their property in violation of the Fifth and Fourteenth Amendments of the United States Constitution.

72. The 2011 DP/NF Rate Reduction has been enacted by the California Legislature, and implemented by the Department, under color of State law. CHA represents the interests of hospitals that have been improperly deprived of their privately enforceable right to be free of government imposed takings of private property without just compensation that is guaranteed under the United States Constitution. Accordingly, the Director has violated 42 U.S.C. § 1983 with respect to the enactment and implementation of the 2011 DP/NF Rate Reduction.

73. Also, the 2011 DP/NF Rate Reduction is preempted by the Supremacy Clause of the United States Constitution, art. IV because the Director cannot simultaneously comply with the provisions of California law requiring the implementation of the rate reduction and the Constitutional prohibition on taking private property without adequate compensation.

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SECOND CAUSE OF ACTION

(VIOLATION OF 42 U.S.C. § 1396a(a)(8)(A)/ SUPREMACY CLAUSE/42 U.S.C. § 1983)

(Against Defendant Director)

74. Plaintiff hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

75. The 2011 DP/NF Rate Reduction is invalid and may not lawfully be implemented because it violates the terms of 42 U.S.C. § 1396a(a)(8) in that the rate reduction is going to effectively prevent many Medi-Cal beneficiaries from obtaining needed skilled nursing care with reasonable promptness. In many areas of

the State Medi-Cal beneficiaries already have to be placed on waiting lists in order to access skilled nursing care. Due to the unprecedented magnitude of the 2011 DP/NF Rate Reduction, Plaintiffs are informed and believe and thereon alleged that many existing DP/NF providers are going to be forced out of business altogether or to severely restrict their services, or reduce the availability of services to Medi-Cal patients. As a result, Medi-Cal beneficiaries will not obtain skilled nursing services with reasonable promptness. In many areas of the State, there simply will be no available capacity at all in DP/NFs or freestanding SNFs. In other areas, there will be no available capacity among Medi-Cal providers of skilled nursing services to accept and care for Medi-Cal patients requiring skilled nursing care who have higher acuity and more complex conditions.

76. The 2011 DP/NF Rate Reduction has been enacted by the California Legislature, and implemented by the Department, under color of State law. 42 U.S.C. § 1983 creates an express cause of action when a state deprives a person of a right secured by federal law. 42 U.S.C. § 1396a(a)(8) secures a right in Medicaid beneficiaries to obtain Medicaid covered services with reasonable promptness. This right is enforceable under 42 U.S.C. § 1983 by Plaintiffs, both the individual beneficiary Plaintiffs and Plaintiff CHA, to the extent it represents the interests of its members' patients.

77. Also, the 2011 DP/NF Rate Reduction is preempted by the Supremacy Clause of the United States Constitution, art. IV because the Director cannot simultaneously comply with the provisions of California law requiring the implementation of the rate reduction and the requirements of 42 U.S.C. § 1396a(a)(8).

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THIRD CAUSE OF ACTION

(VIOLATION OF 42 U.S.C. § 1396a(a)(19) /SUPREMACY CLAUSE/42 U.S.C. § 1983)

(Against Defendant Director)

78. Plaintiff hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

79. The 2011 DP/NF Rate Reduction is invalid and may not lawfully be implemented because it violates 42 U.S.C. § 1396a(a)(19) in that the reduction will effectively dictate that skilled nursing care is being covered and reimbursed, under Medi-Cal, in a manner that is not in the best interests of patients for several reasons. First, DP/NFs often furnish a higher level of care than freestanding SNFS, and are often the only source of higher level skilled nursing care in their communities. DP/NFs will be forced close and/or restrict Medi-Cal services in response to the 2011 DP/NF Rate Reduction, thereby forcing patients to be placed in freestanding SNFs that may not provide the higher level of care that the more complex skilled nursing patients require. It is not in the best interests of higher acuity skilled nursing Medi-Cal patients to be placed in a facility that cannot provide the level of care that they potentially require. Second, the closure of, or reduction in services by, DP/NFs will require patients to be placed in facilities that are very distant from the patients and their families' residences. It is not in the best interest of skilled nursing patients to have to travel long distances to get to a facility that can treat them and that will limit the ability of their loved ones to visit and support them.

80. The 2011 DP/NF Rate Reduction has been enacted by the California Legislature, and implemented by the Department, under color of State law. 42 U.S.C. § 1983 creates an express cause of action when a state deprives a person of a right secured by federal law. 42 U.S.C. § 1396a(a)(19) secures a right in Medicaid beneficiaries to have Medicaid policies in a manner that is consistent with their best interests. This right is enforceable under 42 U.S.C. § 1983 upon Plaintiffs, both the

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individual beneficiary Plaintiffs and Plaintiff CHA, to the extent it represents the interests of its members' patients.

81. Also, the 2011 DP/NF Rate Reduction is preempted by the Supremacy Clause of the United States Constitution, art. IV because the Director cannot simultaneously comply with the provisions of California law requiring the implementation of the rate reduction and the requirements of 42 U.S.C. § 1396a(a)(19).

FOURTH CAUSE OF ACTION

(VIOLATION OF 42 U.S.C. § 1396a(a)(30)(A)/SUPREMACY CLAUSE)

(Against Defendant Director)

82. Plaintiff hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

83. The 2011 DP/NF Rate Reduction violates Section 30(A) of the Medicaid Act because:

(a) The Legislature gave DHCS the authority to reduce DP/NF payment rates, and DHCS exercised that authority, for purely budgetary reasons in order to achieve monetary savings for the State;

(b) Neither the Legislature nor DHCS appropriately considered the factors of efficiency, economy, quality of care and access to services prior to authorizing and/or adopting the 2011 DP/NF Rate Reduction and seeking approval of such from CMS. Despite findings in multiple "studies" performed by DHCS that the rates paid under Medi-Cal to DP/NFs are adequate to ensure continued access to skilled nursing services for Medi-Cal beneficiaries, the Legislature and DHCS have not complied with the procedural requirements of Section 30(A). In particular, the Legislature gave DHCS the authority to implement the 2011 DP/NF Rate Reduction before a study was completed concerning the impact of that specific cut on the availability of skilled nursing services. Plaintiffs are informed and believe and

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thereon alleged that the fact there would be a new reduction in reimbursement for DP/NFs was a foregone conclusion before any purported study regarding that particular payment reduction was completed;

(c) To the extent DHCS sought to amend the State Plan to implement the 2011 DP/NF Rate Reduction after purported studies of that particular reduction were completed, those studies cannot be considered adequate for the purposes of the requirements of Section 30(A). First, Plaintiffs are informed and believe and thereon allege that the Department did not conduct any study of the relationship between provider costs and Medi-Cal payment rates after imposition of the 2011 DP/NF Rate Reduction. Rather, the only studies the State appears to have performed concerned beneficiary access to skilled nursing services. Second, with respect to the Department's conclusions about the impact of the proposed rate reduction on Medi-Cal beneficiary access to skilled nursing services, the Department's studies rely on factually unsupportable assumptions and comparisons and also contain numerous substantive and methodological flaws. Third, the Department's conclusions about continued beneficiary access to skilled nursing services are largely based on historical data concerning provider participation in Medi-Cal under previous payment rates. It is unreasonable to conclude that, because provider participation remained at a certain level under higher payment rates, participation will continue at that level once payment rates are significantly reduced. Finally, the Department's studies do not address all of the requirements of Section 30(A) in that they focus on beneficiary access to services only and do not assess the impact of the rate reduction on quality of care and efficiency;

(d) The rates resulting from the 2011 DP/NF Rate Reduction are not reasonably related to provider costs and therefore are not consistent with quality of care or sufficient to ensure equal access to services. The State's own studies show that, after application of a much smaller, 5% rate reduction, California hospitals would, on average, be reimbursed at less than 80% of the costs they incur in

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providing DP/NF services to Medi-Cal beneficiaries. Accordingly, using the Department's own data, a reduction in rates by more than 20% is going significantly widen the gap between payment rates and costs. Indeed, CHA is informed and believes and on that basis alleges, that Medi-Cal DP/NF payments, as impacted by the 2011 DP/NF Rate Reduction, will, on average, reimburse about 60 to 65 % of DP/NF costs. This discrepancy between Medi-Cal payment rates for DP/NF services and hospital costs is not "reasonable" for the purposes of the requirements of Section 30(A);

(e) The rates resulting from the 2011 DP/NF Rate Reductions are so far below the costs incurred by hospitals in providing DP/NF services to Medi-Cal beneficiaries that the rates are not consistent with quality of care. The reduced rates are lower than the costs efficiently incurred by DP/NFs in providing care to Medi-Cal beneficiaries and therefore are not consistent with quality of care. The reduced rates will result in Medi-Cal patients not having access to the level of care available in a DP/NF, but not available in freestanding SNFs in various areas of the State, and this is not consistent with quality of care. The reduced rates in certain areas of the State will result in patients having to travel to distant locations, away from their homes and families, to obtain skilled nursing services as DP/NFs in their area will close or limit services, which is not consistent with quality of care;

(f) The rates resulting from the 2011 DP/NF Rate Reduction are sufficiently below the costs that hospitals incur in providing skilled nursing services to Medi-Cal beneficiaries that the rates are not sufficient to ensure that Medi-Cal beneficiaries have access to hospital services to the same extent as the general population. As DP/NFs close or reduce the availability of services to Medi-Cal patients, there will no longer be adequate access for Medi-Cal patients to an appropriate level of skilled nursing care.

84. The 2011 DP/NF Rate Reduction is thus preempted by the Supremacy Clause of the United States Constitution, art. IV, because the reduced rates that will

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result from the Reduction, enacted solely for budgetary reasons in disregard of the requirements of Section 30(A), stand as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress in the enactment of said section. Moreover, the 2011 DP/NF Rate Reduction is preempted under the Supremacy Clause because the Director cannot simultaneously comply Section 30(A) and implement and apply the Reduction.

FIFTH CAUSE OF ACTION

(VIOLATION OF STATE LAW/WRIT OF MANDATE, CAL. CODE CIV. PROC. § 1085)

(Against Defendant Director)

85. Plaintiffs hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

86. Plaintiff CHA, on behalf of its members, has a beneficial interest that rates established for DP/NF services comply with the requirements of the California Constitution, California statutes and California case law concerning the obligations and duties of administrative agencies.

87. The Director has a duty to comply with the California Constitution and other California laws, but has violated this duty, by adopting and implementing the 2011 DP/NF Rate Reduction in violation the express terms of Section 14015.192 and Section 19, of Article I of the California Constitution.

88. The 2011 DP/NF Rate Reduction violates Article I, Section 19 of the California Constitution, which prohibits the State from taking or damaging private property for a public use without paying just compensation. California law places restrictions on the ability of participating skilled nursing facilities, including DP/NFs, to both withdraw from Medi-Cal and cease operations. *See, e.g.* Cal. Health & Safety Code § 1336.2 and Cal. Welf. & Inst. Code § 14022.4. Such facilities are not permitted to immediately stop treating patients, but rather must take

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extensive steps to ensure that their patients are transferred to other patient facilities. However, in some instances, this class of facilities may be required, by statute, to continue treating particular patients who refuse transfer to other facilities. Along these lines, skilled nursing facilities, including DP/NFs, may only effectively withdraw from the Medi-Cal program when all Medi-Cal patients have left the care of the facility. California law therefore compels skilled nursing facilities, including DP/NFs, to furnish services to Medi-Cal beneficiaries, which constitutes an appropriation of these facilities and taking of their property by the State of California. Due to the outrageously low rates at which the Medi-Cal program will compensate DP/NFs after the 2011 DP/NF Rate Reduction goes into effect, Plaintiff CHA's members that operate DP/NFs will not be justly compensated by the State for their property in violation of Article I, Section 19 of the California Constitution.

89. The 2011 DP/NF Rate Reduction was implemented in a manner inconsistent with the terms of Section 14105.192. Under Section 14105.192, the Director is only authorized to implement, among other rate reductions, the 2011 DP/NF Rate Reduction based on a determination, "that that the payments that result from the application of this section will comply with applicable federal Medicaid requirements and that federal financial participation will be available." Welf. & Inst. Code § 14105.192(m). Under California law, administrative agencies are prohibited from acting in manner that is arbitrary, capricious, inconsistent with applicable law or lacking in evidentiary support. Further, agency decisions must be based on a consideration of all relevant factors and must demonstrate a rational connection between those factors and the choice made. Here, the Director's decision that the rates that will result from the 2011 DP/NF Rate Reduction will comply with the requirements of the federal Medicaid Act is arbitrary, capricious and lacking in evidentiary support because, among other reasons: (1) the Director effectively ignored evidence showing that DP/NFs services are not interchangeable with freestanding SNF services and evidence showing that DP/NFs have been closing at a

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steady rate recently in concluding that beneficiary access to skilled nursing care would not be impacted by the rate reduction; (2) the Director failed to adequately consider the factors of quality of care and efficiency in evaluating whether the 2011 DP/NF Rate Reduction meets Medicaid Act standards; and (3) the Director failed to account for governing law establishing that, under Section 30(A), provider payment rates must bear a reasonable relationship to the costs efficiently and economically operated providers incur in treating Medicaid beneficiaries.

90. Plaintiffs have performed all conditions precedent to the filing of the petition for mandamus. No other adequate remedy exists under statute, regulation or other provisions of law. Under California law, the existence of declaratory and injunctive relief does not prevent the use of mandate. *County of Los Angeles v. State Department of Public Health*, 158 Cal.App.2d 425, 446 (1958).

SIXTH CAUSE OF ACTION

(VIOLATION OF

ADMINISTRATIVE PROCEDURE ACT, 5 U.S.C. §§ 701-706)

(Against Defendant Secretary)

91. Plaintiff hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

92. Under the federal Administrative Procedure Act ("APA"), 5 U.S.C. §§ 701-706, courts must overturn agency action that is arbitrary, capricious, an abuse of discretion or not otherwise in accordance with the law.

93. The Secretary's approval of the SPA setting for the 2011 DP/NF Rate Reduction is the act of an administrative agency and subject to review under the APA. The Secretary's approval of the SPA is invalid under the APA because it is arbitrary, capricious and an abuse of discretion, and otherwise inconsistent with governing law, for the following reasons:

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(a) Because California is within the jurisdiction of the Ninth Circuit Court of Appeals, the Secretary is bound to apply the Ninth Circuit's interpretation of the Medicaid Act, including Section 30(A), when evaluating California SPAs for compliance with the Medicaid Act. The Ninth Circuit has held that Section 30(A) requires that Medicaid payment rates must be based on credible cost studies and must bear a reasonable relationship to provider costs in order to be consistent with quality of care and sufficient to ensure that beneficiaries have equal access to services. CHA is informed and believes, and on that basis alleges, that the Secretary has not applied the Ninth Circuit's interpretation of Section 30(A) in reviewing and approving the relevant SPA, but purported to consider only whether the rates may actually cause a reduction in beneficiary access to services. The Secretary has thus failed to follow and apply the applicable law;

(b) The question of whether Medi-Cal payment rates for DP/NFs are reasonably related to hospital costs is a relevant factor in the determination of whether the rates comply with Section 30(A). Plaintiffs are informed and believes, and based thereon alleges, that the Secretary did not consider whether the Medi-Cal payment rates for DP/NFs after the implementation of the 2011 DP/NF Rate Reduction would bear a reasonable relationship to hospital costs in deciding to approve the relevant SPA;

(c) Plaintiffs are informed and believe and thereon allege that payment rates resulting from the 2011 DP/NF Rate Reduction will generally reimburse DP/NFs roughly 60- 65% of their costs. Accordingly, the Secretary could not have reasonably concluded that the rates resulting from the 2011 DP/NF Rate Reduction bear a reasonable relationship to costs. It was therefore arbitrary, capricious and an abuse of discretion for the Secretary to approve the relevant SPA;

(d) Plaintiffs are informed and believe and thereon allege that the Secretary did not consider other relevant factors in evaluating California's SPA related to the 2011 DP/NF Rate Reduction in that the Secretary did not adequately

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consider, among other things, the impact of the rate reductions on the quality of nursing care, whether the payment reduction would impact the promptness with which Medicaid beneficiaries are able to obtain skilled nursing services and whether the reduction would impact the efficiency with which Medi-Cal services are delivered, perhaps through effectively eliminating certain DP/NF providers and thereby forcing Medi-Cal beneficiaries to either obtain care in freestanding skilled nursing facilities, which are not ideally suited to the level of care they need, or in acute care areas of hospitals, which provided more expensive care than DP/NFs;

(e) The record before the Secretary at the time she approved the SPA at issue demonstrates that the DP/NF Rate Reduction will adversely impact quality of care, and would not be sufficient to ensure that Medi-Cal beneficiaries would have equal access to services, because, among other things, the 2011 DP/NF Rate Reduction, which is effectively three reimbursement reductions rolled into one, will cause a significant deterioration in the financial health of many hospitals that will cause hospitals, among other things, to cut back, reduce and eliminate DP/NF services. The record before the Secretary demonstrates that hospitals that will be forced to take these types of actions include rural hospitals and critical access hospitals which are in many instances the only source of skilled nursing services for a large geographic region of the State. As a result, both Medi-Cal beneficiaries and other California residents will be faced with a situation in which needed health care services are not available, either at all, or within a reasonable time or distance. Further, with respect to quality of care, the evidence before the Secretary showed that, as DP/NFs close or reduce the availability of services to Medi-Cal patients, there will no longer be adequate access for Medi-Cal patients to an appropriate level of skilled nursing care;

(f) The Secretary's review and approval of SPA 11-010 also is arbitrary and capricious because it occurred in manner that was inconsistent with the Secretary's own public statements concerning the need for "transparency" in the

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SPA approval process. Interested parties, including CHA, were not afforded meaningful access to the information that was being exchanged between CMS and DHCS concerning the SPA. Rather, the only reason any of this information was provided at all was because CHA exercised its rights to public information under FOIA and California's PRA. Even then, DHCS refused to make the information available until after CMS made its decision to approve or disapprove the SPA, and CMS did not make information available to very shortly before it made its approval decision. Further, CMS refused to delay its approval decision to allow CHA to review and consider all of the information DHCS submitted in support of SPA 11-010. By reaching a decision on SPA 11-010 without affording interested parties an adequate opportunity to review the information DHCS submitted in response to CMS' RAI, the Secretary effectively rendered meaningless any public participation she had allowed in the process before that.

SEVENTH CAUSE OF ACTION

(DECLARATORY RELIEF)

(Against All Defendants)

94. Plaintiffs hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

95. An actual and justiciable controversy exists between Plaintiffs and Director regarding the validity of the 2011 DP/NF Rate Reduction. Plaintiffs, including Plaintiff CHA on behalf of its members and its members, Medi-Cal patients, contends that the reimbursement reduction is invalid and unlawful in violation of the United States Constitution, the California Constitution, federal statute and State laws, while the Director contends that the reimbursement limitations are valid in all respects.

96. An actual and justiciable controversy exists between Plaintiffs and Defendant Secretary regarding whether the SPA setting forth the 2011 DP/NF Rate

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Reduction complied with the requirements of the federal Medicaid Act. Plaintiffs contend that the Secretary's approval of the relevant SPA was arbitrary, capricious, an abuse of discretion and not in accordance with applicable law, while the Secretary contends that she properly approved the SPA as in compliance with the Medicaid Act and APA.

97. Accordingly, pursuant to 28 U.S.C. § 2201, Plaintiffs request this Court to declare that the 2011 DP/NF Rate Reduction is invalid, unlawful and preempted by federal law.

98. No administrative appeal process or other administrative remedy is available to Plaintiffs and/or Plaintiff's members, as applicable, to challenge the 2011 DP/NF Rate Reduction.

99. All of the said injuries are great, immediate, and irreparable, for which damages at law are inadequate, and for which Plaintiffs, and/or its members, have no plain, adequate or speedy relief at law or otherwise.

WHEREFORE, Plaintiffs pray for judgment as follows:

1. For an Order declaring that the 2011 DP/NF Rate Reduction violates the Takings Clause of the United States Constitution, the Takings Clause of the California Constitution, Section (a)(8), Section (a)(19), Section 30(A), the APA, California law and is thus invalid and/or preempted by the Supremacy Clause of the United States Constitution, art. IV;

2. For an Order declaring that it was arbitrary, capricious, an abuse of discretion and not in accordance with applicable law for the Secretary to approve the SPA purporting to incorporate the 2011 DP/NF Rate Reduction into California's State Plan.

3. For an Order setting aside the Secretary's approval of the SPA purporting to incorporate the 2011 DP/NF Rate Reduction into California's State Plan.

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4. For an Order preliminarily and permanently enjoining the Director from effectuating the 2011 DP/NF Rate Reduction;

5. For the costs of suit, including reasonable attorneys' fees incurred by Plaintiffs, as permitted under 42 U.S.C. § 1988 or otherwise, and

6. Such other and further relief as may be just and proper.

DATED: November 1, 2011

HOOPER, LUNDY & BOOKMAN, INC.

By: _____
JORDAN B. KEVILLE
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